Montefiore Hudson Valley Collaborative

Introduction

The Montefiore Hudson Valley Collaborative (MHVC) was pleased to successfully complete the IA review and public comment phases of the Mid-Point Assessment without any formal recommendations. Below we have addressed the specific areas of concern raised by the state-appointed DSRIP Project Advisory and Oversight Panel on MHVC's funds flow to Tier 1 Community Based Organizations (CBOs). As MHVC did not receive any recommendations as it pertains to "at-risk" project implementation or provider engagement speed and scale, our narrative addresses funds flow to CBOs.

Mid-Point Assessment Recommendation

Part 1	**CBO Strategy and Timeline for Engagement Overview**	The PPS must develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Use Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement.
Part 2	**Funds Flow Approach**	The PPS is providing a description of the PPS funds flow strategy for project implementation and performance incentives to partners throughout the term of the DSRIP program including projected budget percentages of total PPS budget to be provided in the funds flow template. The Plan must outline a detailed timeline for meaningful engagement.
Part 3	**Not Applicable** The PPS does not have any deficiency in this area and therefore no response is needed.	The PPS shall provide report on how the PPS will ensure successful project implementation efforts with special focus on projects identified by the IA as being at risk.

PPS Action Plan Narrative

Part 1: CBO Strategy and Timeline for Engagement Overview

MHVC has developed a mature contracting and funds flow structure that values network providers' ability to impact the health outcomes of our attributed population. MHVC's contract deliverables have allowed the network to incentivize the incremental change required to ensure that care is coordinated for patients. As articulated in our Mid-Point Assessment narrative and in our January 2017 CBO survey response, MHVC has developed an incremental strategy for CBO integration. Each component of our strategy will include either Direct or Indirect funds flow to CBOs through direct payment of funds and/or resources to include technical assistance, consulting services, and/or infrastructure.

This three-tiered strategy includes the following components:

- **Component 1: Outreach & Empowerment (DY2-4)**

MHVC's work to date with CBOs, as described in detail in our CBO Survey, is aligned with Component 1: Outreach & Empowerment. Funds have been leveraged to provide technical assistance and consulting

services to CBO partners. This includes time spent getting to know the CBOs in our network through organic engagements, regional forums, and facilitated structured assessments. Additionally, through our partnership with New York Association of Psychiatric & Rehabilitation Services NYAPRS and the Public Health Council, we have worked to connect CBO partners to existing resources and developed new resources and curriculum to support sustainability. Funds flow opportunities will continue to include consulting, training (i.e. Plan-Do-Study-Act (PDSA)) and infrastructure (i.e. referral system implementation (NowPow))

- **Component 2: Defining Target Interventions (DY3-5)**

Much of the narrative below and the associated Implementation Plan speaks directly to our CBO Contracting strategy. The strategy utilizes the knowledge gained in Component 1 to develop targeted CBO contracts based on delivering clearly defined interventions and reporting on key metrics. Funds flow opportunities will include direct funding through contracts and potential to earn additional funding through the MHVC Innovation Fund.

- **Component 3: Supporting Sustainability (DY 3-5)**

This component will be a natural culmination of the work completed in the previous components. Sustainability is at the core of all of our work streams, including our CBO integration strategy and in this component direct contracting and MSO relationships with CBOs will strengthen sustainability at the network and partner level. The principle of sustainability drives our work around CBO Empowerment (Component 1) and our work to create meaningful contracts for interventions (Component 2) that value CBO expertise and relationships and utilizes data to establish a tangible value proposition.

The following provides specific actions that flow from our strategy:

Since our presentation to the PAOP in February 2017, MHVC has established a formal work plan/implementation plan for CBO Contracting. This is aligned with Component II of our CBO Integration Strategy - Defining Target Interventions. The implementation plan provides detailed action items in accordance with four milestones defined below:

- Define Core Services for CBO contracts
- Define Initial Focus Areas (Based on Community need and assessed CBO expertise)
- Identify targeted CBOs -SMEs (Tier 1-3) and Implementers (Tier 1)
- Execute contracts (initial focus on "hot spots:" Yonkers and Newburgh)

Work Plan:

CBO Contracts will be implemented for the following core services: patient education, patient navigation and patient engagement activities. Focus area/curriculum for CBO contracts will be prioritized based on articulated regional needs, potential impact on the health or wellness of consumers and availability of existing curriculum for rapid deployment.

Our contracting strategy will utilize a two-pronged approach for CBO contracts with distinct roles and responsibilities for each organization.

1) **Subject Matter Experts (SMEs)** - Tier 1, 2 or 3 CBOs
   The "SME" contracts will compensate CBOs for designing and/or deploying curriculum (train the trainer) to Tier 1 CBOs. This approach values the expertise within our network, and allows us to be responsive to distinct regional needs. We recognize the value of leveraging established national curricula on patient education such as those developed by Stanford University and John's Hopkins University in areas such as asthma, cancer screenings, and diabetes management. If curriculum does not exist or should be built specific to engage a population in a region (e.g.: How to access care?), MHVC will engage with CBO partners to develop or facilitate its development.

2) **Implementers** - Tier 1 CBOs.
   The "Implementer" contracts will compensate CBOs for deploying curriculum to consumers. Implementer contracts will contain reporting requirements around actions (i.e.: referrals to Health Home, referrals to Primary Care) to establish a data driven value proposition for sustainability. Implementer contracts recognize the ability of Tier 1 providers to engage patients that may be disconnected from the healthcare continuum.

Central to this contracting strategy is reliance on a rapid feedback loop to ensure that regional needs continue to be identified, and curriculum development prioritized and deployed as appropriate. MHVC will utilize regional focus-groups, organic partner engagement and structured surveys to ensure strategy refinement and expansion.

Timeline for Contracting:

MHVC will have CBO contracts in place by September 30, 2017 as articulated in our implementation plan.

Monitoring Protocol:

MHVC's Project Management Office (PMO) and leadership will monitor progress of the CBO contracting implementation plan, utilizing the already established process for reviewing DSRIP milestones. In order to support this effort, MHVC has imported our implementation plan into Performance Logic, our internal PMO system, which allows for reporting oversight and risk management.

Alignment with Larger PPS DSRIP Strategy:

These actions directly align with our commitment to strengthening the communities of care within the Hudson Valley while flowing funds in a responsible and sustainable way. These actions further strengthen our commitment to ensure that community resources are valued and built into the care continuum rather than duplicated. Through leveraging our partnership with CBOs, we can strengthen the greater network of DSRIP providers. CBOs know their community members and often have established a trusting relationship with the patients in our network. Providing CBOs with tools, processes and contracts that quantify their impact provides them a mode to demonstrate, and be compensated for, their value in an integrated delivery system.

The following section describes our approach to funds flow.

Part 2: Funds Flow Approach

MHVC is committed to a funds flow model that is a careful steward of state and federal dollars and distributes funds in a thoughtful, fair, and equitable manner. At the same time this model recognizes critical MHVC partners and supports the development of an Integrated Delivery System infrastructure to ensure a financially stable future for MHVC partners in the Hudson Valley.

Over the course of DY1 and DY2, MHVC worked closely with partners (including the Finance and Sustainability Subcommittee, Clinical Quality Subcommittee and ad hoc partner workgroups) to develop a funds flow methodology that supports DSRIP project implementation success.

The funds flow process is highly iterative and will continue to be revised as DSRIP and the MHVC network matures. In late 2015, MHVC contracted with partners via a Phase I funds flow focused on network development. In Phase I of contracting, MHVC focused on the MHVC partners that represented more than 90% of our network attribution. This group of 50 partners was eligible to receive $5M in partner payments. In early July 2016, MHVC's Phase II contracts were released with a focus on partner roles and responsibilities for program implementation and clinical outcomes. More detail on both phases can be found below. Phase II contracts took MHVC's targeted partner list from 50 to 69 and increased the allocated partner funding from $5 million in Phase I to $7.2 million in Phase II, Performance Period I. Further, the evolving structure of contracting currently have partners earning 75% of funds via successful completion of Project Milestones and 25% of funds earned via the MHVC's ability to successfully meet clinical outcomes set and measured by New York State. As of March 10th MHVC has approved $4,068,571 to partners that have executed and implemented their Phase II, Performance Period I contracts and will shortly complete review of this period in order to flow all eligible funds.

In March 2017 MHVC launched Phase II, Performance Period II contracts with a total maximum envelope of $8.7 million committed to partner payments. Performance Period II will continue to hold partners accountable for both process and outcome metrics. However this performance period builds on the success and network learnings of Performance Period I by assigning metrics and dollars down to the organizations unique site level. This round will also introduce tiered metrics that take into account the infrastructure and readiness of individual partners, including PCMH status and EHR implementation. This level of sophistication allows MHVC to continue its commitment to being a responsible steward of Medicaid funds by getting the most impact from each partner payment.

Funds Flow Guiding Principles:

Context of DSRIP funding

The overall goal of DSRIP is to catalyze the transition from a fee-for-service system to a value-based system. DSRIP funds can cover a portion of the costs necessary to transition to a value-based system. However, MHVC recognizes that there are additional drivers of transformation that are necessary to ensure a financially viable health care system. Partners that chose to participate in the MHVC network will be expected to carry some of the financial responsibility for funding their organizational transformation realizing that the path to financial sustainability will include sources of value beyond DSRIP incentives including:

- Increased revenue from out-patient and primary care

- Reduced migration of patients to partners outside of MHVC and the region
- Operational efficiency due to greater scale
- Reduced fixed cost and variable cost savings
- Value-based contracts

High-level allocation of funding

The MHVC budget and funds flow methodology aligns with definitions set forth in the MHVC Implementation Plan and are aligned with the budget projections reported in the December 2014 MHVC Lead Agency DSRIP application. Funds are allocated to the following budget categories:

Montefiore HUDSON VALLEY COLLABORATIVE

MHVC 5-Year Funds Flow Average by Bucket

Budget Category	%
Cost of Project Implementation	45%
- Administrative costs including network management, DSRIP program office administrative support for PPS operations, legal support, PPS compliance - Centralized services will support creating shared infrastructure of the PPS and will include costs of shared IT infrastructure (to support performance reporting and data sharing), care management functions, central training and workforce development. Costs of implementation will be higher in the initial years to reflect the financial needs to set up DSRIP infrastructure (mirroring process and reporting metrics)	
Revenue Loss	10%
- Some partners will experience revenue decline in Medicaid population, as well as in Medicare and commercial populations Designed with the aim to help providers overcome the initial period of set-up costs and lost revenues while focusing on the right metrics as they grow and transform their services - To qualify for revenue loss compensations, partners will need to meet both progress and performance benchmarks and demonstrate ability to shift to sustainable system	
Internal PPS Provider Bonus Payments	40%
- Support project implementation and continued care delivery transformation - Provide reimbursement for services not currently covered under existing FFS contracts - Reward partners for outperforming on target milestones - The gradual shift from process to outcome measures aims to mirror the DSRIP incentive structure - Building on existing ACO experience, distribution of funds will be based on attribution, case mix and partners' performance against project milestones & performance measures	
Other (Contingency and Innovation)	5%
- Funds dedicated for continuous innovation and piloting new clinical programs - Discretionary funding to account for unforeseen expenses or underperformance	
Total	100%

Considerations for funds flow to partners

We have designed the MHVC funds flow methodology to closely mirror the DOH methodology. Funding will be tied directly to stakeholders' role in projects and outcomes and will be distributed to partners by assessing the patient population impacted by the projects. As the needs of each partner may be slightly different, partners will have autonomy and will maintain control over individual budgets and implementation plans (in close collaboration with the MHVC office). Contract deliverables ensure that partners provide regular status updates to ensure DOH milestones and requirements are met. Reflecting how MHVC will earn incentive payments from the DOH, partner funds will be increasingly tied to performance over the course of DSRIP (25% in Phase II of contracting).

MHVC's Phase I of funding (October – December 2015) was allocated to partners based on provider type, network development needs and member attribution. Phase II funding began in July 2016 and is organized into three contract periods. Each contract period will reflect the most current data available from DOH related to member attribution and a partner's claims history as well as a partners role in Project Milestones, their use of shared services and regional needs. Additionally funds flow will continue to adhere strictly to the "95/5" safety net rule that ensures that 95% of partner payments are distributed to safety net entities.

MHVC Funds Flow Key Compliance Principles

- No payments will be made to partners before MHVC receives payment
- No payments will be made to partners without executed contracts
- Funds Flow methodologies are created through a collaborative process with the MHVC Finance and Sustainability Subcommittee and submitted to the MHVC Steering Committee for review and feedback

MHVC will ensure that the roles of CBOs continue to be valued in the funds flow methodology by recognizing their critical role in regional communities of care in a value based environment. This includes the commitment to flow significant funds to Tier 1 CBOs by the end of DY3Q2. As reported in the Mid-Point Assessment funds flow table, MHVC has committed 2.5% of funding to CBOs for the duration of the DSRIP program. This is the maximum possible to keep MHVC in compliance with the state mandated "95/5" rule to flow a maximum of 5% of funds to non-safety net providers (including Tier 1 CBOs) In the following section we will outline the strategy, implementation plan, timeline and funding that will be dedicated to CBOs in the immediate and long term.

Montefiore Hudson Valley Collaborative
Implementation Plan
Community Based Organization (CBO) Strategy

CBO Strategy Implementation Plan	
Defined Milestones/Tasks	***Target Completion***
1. Defining Core Services for CBO Contracting (Based on Needs of Network)	3/16/2017
Facilitate internal brainstorming session with appropriate SMEs- Network, Clinical, Workforce and Research and establish standing meeting recurrence	2/15/2017
Define scope and approach for CBO contracts	2/23/2017
Define core services & pilot areas	2/23/2017
Present to MHVC - Steering Committee for feedback	2/23/2017
Develop CBO contracting work plan	3/1/2017
Present recommendations and rationale to CQS and solicit feedback	3/16/2017
2. Define intial focus area(s) (patient education, navigation, engagement)	4/30/2017
Define criteria to be used to identify initial focus area (need/existing curricula/impact on outcome)	4/6/2017
Solicit feedback from contracted partners on needs using Subcommittees, Workgroups, etc.	4/30/2017
4. Identify CBOs with the capacity to serve as SMEs (Tier 2 and 3) and Implementers	5/15/2017
Evaluate CBO expertise/ capacity to develop curricula or deliver focus area	4/7/2017
Define proposed selection criteria for CBOs (SMEs & Implementers and Identify CBOs) and draft decision tree	4/14/2017
Finalize target list for CBOs (SMEs, Implementers)	5/30//2017
5. Execute Contracts with CBOs	9/30/2017
Determine contracting structure, funding and outcome measures	6/15/2017
Develop Guidance Documents and reporting criteria for contracting	7/31/2017
Execute CBO contracts	9/30/2017

State of New York
Department of Health
Delivery System Reform Incentive Payment (DSRIP) Program
Mid-Point Assessment Action Plan - Funds Flow

		Funds Flow (all funds)			
Partner Category		***Funds Flow through DY2, Q3***	***Projected Funds Flow through DY2***	***% of Earned Dollars Planned for Distribution DY3***	***% of Earned Dollars Planned for Distribution DY4 - DY5***
Practitioner - Primary Care		$ 1,518,047	$ 2,214,710	4.9%	9.4%
Practitioner - Non-Primary Care		$ 238,162	$ 316,376	0.6%	1.1%
Hospital - Inpatient/ED		$ 1,934,236	$ 2,201,547	1.9%	3.6%
Clinic		$ 2,438,777	$ 3,133,199	4.9%	9.4%
Mental Health		$ 1,941,227	$ 2,752,016	5.8%	11.0%
Substance Abuse		$ 1,277,176	$ 1,639,312	2.6%	4.9%
Community Based Organization (Tier 1)		$ 6,000	$ 6,000	2.5%	2.5%
Nursing Home		$ 128,235	$ 337,531	1.5%	2.8%
Pharmacy		$ 6,532	$ 6,532	0.0%	0.0%
Hospice		$ 1,169	$ 3,296	0.0%	0.0%
Community Based Organization		$ 5,650	$ 5,650	0.0%	0.0%
All Other		$ 538,976	$ 722,810	1.3%	2.5%
Case Management/Health Home		$ 538,843	$ 934,051	2.8%	5.3%
Partner Payments Sub-total		**$ 10,573,030**	**$ 14,273,030**	**28.8%**	**52.6%**
Administration		$ 2,218,619	$ 2,748,080	5.6%	5.7%
Project Implementation		$ 12,725,759	$ 15,196,298	36.8%	26.4%
PPS PMO Sub-total		**$ 14,944,378**	**$ 17,944,378**	**42.5%**	**32.1%**
Revenue Loss		**$ -**	**$ -**	**9.4%**	**12.9%**
Innovation		**$ -**	**$ -**	**9.7%**	**1.2%**
Contingency		**$ -**	**$ -**	**9.7%**	**1.2%**
Grand Total		**$ 25,517,408**	**$ 32,217,408**	**100%**	**100%**

Notes 1) Actuals thru DY2Q3 from MAPP reporting